Independent People Homecare Limited

Independent People Homecare Services Limited

Inspection report

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Date of inspection visit:
09 October 2018
10 October 2018

Date of publication:
14 November 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on the 09 October and 10 October 2018 and was announced.

This service is a domiciliary care agency. It gives personal care to people living in their own houses. It provides a service to older adults. On the day of our inspection, there were 139 people using the service, all of which received personal care.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the ongoing rating of good. There was no evidence or information from our inspection that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At the time of inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People were safe at the service. Staff knew what action to take if abuse was suspected. Some people told us that they had experienced missed or late visits on occasions. We have made a recommendation about missed and late visits. A robust recruitment and selection process was in place.

Staff had a good understanding of how to manage medicines. People's medicines were managed so that they received their medication at the right time and in the right way.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff were kind and had developed good relationships with people using the service. People told us they were comfortable in the presence of staff. People told us staff were caring and looked after them well. People were provided with the care, support and equipment they needed to stay independent.

Systems were in place to manage compliments and investigate complaints. Staff understood the importance of supporting people to have a good end of life as well as living life to the full whilst they were fit and able to do so. End of life care plans include people's wishes to ensure that people's passing was comfortable, pain free and as peaceful as possible.

People were involved with care planning and staff knew people well and were aware of their personal histories. Positive relationships had developed between people and the staff that supported them. Information included guidance for staff so they could follow a structured approach to recognise and manage people's health conditions and behaviour.

Robust systems were in place to seek the views of people who used the service, and check the quality. Spot checks, care planning review meetings and audits were carried out on a regular basis. Feedback about the service was used to review the service and to make improvements.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 09 and 10 October 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to respond to our queries.

The inspection team consisted of two inspectors' and one expert by experience, who carried out phone calls after the visit to the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and improvements they plan to make. They did return a PIR and we took this into account when we made the judgements in this report. We reviewed all the information we had available about the service including notifications sent to us by the manager. Notifications are information about important events, which the provider is required to send us by law. We also looked at information sent to us from others, including family members and the local authority.

During the inspection, we visited the agency's office and spoke with the registered manager, two directors, seven members of staff, nine people who used the service and a friend of a person who used the service.

We looked at 11 people's care records and ten staff records. We inspected information relating to the management of the service such as health and safety records, personnel and recruitment records, quality

monitoring audits and complaints. Healthcare professionals were approached for comments about the service and any feedback received has been included in the report.

Good

Is the service safe?

Our findings

People using the service told us they felt safe when being supported by staff in their own home. One person said, "Oh I am quite safe. I have one call in the evening to make sure I am safe. They bed me down for the night. I am so safe knowing they are checking on me." Another person said, "Yes, very safe. They have helped me no end with my physio and got me to get out of bed on my own as I was very unsteady."

Systems and procedures were in place to safeguard people. Staff attended training and were knowledgeable about how to identify abuse. Staff and the registered manager knew how to report concerns in the right way. Staff told us they were confident the registered manager would act to deal with any safeguarding concerns that were raised with them.

Records showed that safeguarding concerns were recorded and reported to the local authority and the Care Quality Commission (CQC) when necessary. The registered manager looked at ways learning could take place when things had gone wrong, and used this to look at how the service could be improved. For example, following a recent safeguarding concern, a new handover sheet had been introduced to ensure that a consistent handover of information between live in care staff.

Some people told us that they had experienced missed or late visits on occasions. One person said, "Most of the time it's okay, but they have missed me a couple of times. Sometimes they come as late as 10pm for my night call. At least they do stay for the right amount of time when they do arrive. No, they do not call to let me know if someone is running late. I have to phone them the next day to say nobody came." Another person said, "No, I never know what time they are coming but they always turn up. I am not bothered by the time as I am always here and they always get to me by lunch time." In these cases, we did not find that people had been left at risk of harm.

The registered manager said that the senior checked at the end of each round to make sure that staff were out delivering care. One staff member said, "Not everyone has electronic monitoring. So, we may not find out if staff haven't turned up until the next visit. We are reliant on staff members or people telling us."

We recommend the registered provider obtains best practice guidance around ways in which to improve the way missed or late calls are managed and risks identified.

Systems were in place to promote people's safety. Detailed assessments identified risks to safety and wellbeing. Care plans had individual risk assessments which provided guidance for staff to know how to work in a safe way. For example, there was detailed information for staff to understand how to support people if they were at risk of falls, malnutrition, dehydration, or if they were at risk of developing pressure ulcers. The effects on that person if guidance was not followed, was also included. For example, in one care plan there was detailed information relating to how to communicate with the person and how this affected them if the guidance was not followed.

The service had a robust staff recruitment system. All staff had references and DBS checks were carried out.

DBS stands for Disclosure and Baring Service and is a check to see if prospective staff have any criminal convictions or are on any list that bars them from working with vulnerable adults.

Arrangements were in place to support people's medicines safely, if this was needed. One person said, "Yes they do my meds. They get them out all ready for me and give me them with some water, always wearing gloves and aprons. They see I take them and put it all down in the book here." Another person said, "All my medicines are given to me on time without fail. I have type 2 diabetes. Yes, they always wear gloves and aprons when seeing to them."

Audits were carried out to ensure that medicine records were up to date and correct and all staff received the right training prior to administering medicines. Staff members confirmed that they had been trained and felt confident to administer people's medicines. Regular spot checks were carried out to make sure they were competent.

People were protected from the risk of infection. Staff had been given infection control training and had been given personal protective equipment (PPE) to use. For example, disposable gloves and aprons. Everyone we spoke with said, that staff wore gloves which they would bring with them and dispose of at their home. They also said staff wore a uniform and looked clean and tidy.

Good

Is the service effective?

Our findings

People told us they were supported by staff who were trained and knowledgeable. One person said, "Yes they all well trained and knowledgeable in my opinion. They have helped me no end with my rehabilitation and got me mobile." Another person said, "Oh yes. They are all very good. All of them. I have no issues with their training or knowledge of how to do things at all."

All staff received an induction and training programme. Staff were encouraged to complete the care certificate or progress to complete further qualifications in Health and Social care. Information showed that a wide variety of training and development was on offer to new staff, and the provider had significantly invested in this area of the service. Mandatory training was offered to people, and included specialist training, like cerebral palsy, epilepsy catheter and stoma care.

Elements of the approach the provider took around the training and development of staff was excellent. Training sessions were a mixture of both experiential classroom and eLearning sessions. Three days mandatory training was given and live in carers were required to complete a residential course.

The trainer was very qualified and competent to undertake the training role. The trainer completed observations to make sure staff were competent to deliver care to people, following their training. A large component of the training was practical sessions. Practical sessions included sensory training. This training gave the staff member an opportunity to experience the care that would need to be given. For example, during training staff were hoisted and sessions were given so they could experience sensory loss. This encouraged staff to explore how certain aspects of care may affect people and encourage them to empathise with sensory loss. The provider had recently partnered with a local training provider to enable them to deliver their own diplomas in Health and Social care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA and found that staff had a good awareness of capacity and consent. Staff had completed Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training.

Everyone told us that staff asked for their consent before carrying out care tasks. One person said, "Yes I do. If feeling unwell they respect this and I may decide to have a wash rather than move to the shower. They are fully supportive of my views."

We inspected people's information and found that consent had been obtained and was recorded within each care plan. Where a person had a lasting power of attorney in place it was recorded. A lasting power of attorney (LPA) is a way of giving someone the legal authority to make decisions on a person's behalf if they lack mental capacity. When a person did not have a lasting power of attorney in place, records relating to

the court of protection was also considered. At the time of our inspection no one required the support of an Independent Mental Capacity Advocate (IMCA). An IMCA provides statutory advocacy and gives some people who lack capacity a right to receive support from an IMCA.

People were supported to eat and drink in a safe way, and their food preferences and choices were recorded. For example, one care plan said, "[Name of person] dislikes cheese and olives, but will tell you what they fancy, so you can get it out of the freezer." One staff member said, "[Name of person] only likes their tea, with their tea bag, 'dipped in and dipped out' they must see the bottom of the cup. It's very important to get it right."

Staff had detailed guidance available to them when people needed support to help them to eat and drink safely because they were at risk of choking. Information had details for staff about the type and texture of the food the person required. This information included guidance for staff explaining what to do in the event of someone choking. Information reflected guidance from speech and language professionals involved in people's care.

People's oral health care needs was considered, and specific care plans were in place. Oral care was used to give people the opportunity to have control over their day to day lives. For example, one care plan said, "[Name of person] is able to clean their own teeth. Make sure [name] is sat upright and give instructions. [Name] will need a plastic beaker and bowl which is in the bathroom to rinse and spit toothpaste."

Information reviewed during the inspection showed the involvement of health and social care professionals and staff had worked with various agencies to make sure people accessed other services in cases of emergency, or when people's needs had changed. For example, GP's, occupational therapists, mental health team and social workers. Advice and guidance provided by external health and social care professionals were reflected in people's care records. This meant staff had the correct information available to work with professionals to ensure the individual needs of the people were met.

Good

Is the service caring?

Our findings

People using the service told us staff were caring and treated them with respect. One person said, "I am very happy with the carers. They are all very kind and polite with me." Another person said, "It's the times that are the problem. All staff are nice and polite and helpful. They are considerate of my needs." Another explained, "They certainly are caring. I am very happy with all of them. They all display warmth, consideration and care."

Staff spoke with affection about the people they cared for and people told us they had developed good relationships with the staff that supported them. Staff were aware of the impact their visits made to people's lives. For example, people were involved in decisions about their care and staff were skilled at making sure people were in control, and they realised that this took time.

People told us their privacy and dignity was respected by the staff working with them. One person said, "Yes they are most respectful. When they shower me, they make sure I get covered up when coming out." Another person said, "This is fine. They are most respectful and careful when washing and dressing me."

Where people could not communicate verbally, staff had detailed guidance about how the person communicated their wishes. One care plan instructed staff to make sure that they ensured that a person hearing aid was correctly fitted to the person's right ear, and to ensure that their glasses were clean and smear free."

Staff were aware of people's personal preferences and care plans had very detailed information and guidance about how to give person centred care. Within the care plans we saw that personal interests, hobbies, likes and dislikes, religious and cultural needs had been explored, along with people's preferences about whether they wanted a male or female carer. One person said, "I have told them that I prefer to have women and that is who they send."

At the time of the inspection nobody at the service required the help of an advocate, but the registered manager said they would be able to link people with their local service. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on the issues that are important to them.

Good

Is the service responsive?

Our findings

People using the service told us staff responded to them and met their individual needs. One person said, "Yes. [Name of staff] has helped me immensely with getting me back to being mobile, and being able to dress and wash myself. They have gone above and beyond, helping me with movement exercises and mobility."

Care records held referral information from local authority and health commissioners, and included a breakdown of people's care and support needs. Assessments were in place which covered a wide range of topics, from moving and handling, to people's spiritual and cultural needs. People's care plans described how each person should be supported.

Each person had a care plan in place, with guidance for staff about how the person preferred for their care to be delivered. These were fully person centred and gave guidance for staff to understand how to deliver the care and support people needed, in the way they preferred. People's strengths and levels of independence were identified and care plans were regularly updated with relevant information.

People told us they were involved in reviewing their care. One person said, "I have full input into my care plan. It's all reviewed and up to date." Another person said, "My husband sees to that but I do have input into it. It is all up to date and a copy is here."

Daily records were well written and had a good level of detail about the care that had been given and any other issues or key events that had happened during the visit. Staff could outline the needs of the people they were supporting. They could explain how they would check the support plan to see if there had been any changes since their last visit.

Systems continued to be in place to investigate complaints. We saw that the registered manager had responded appropriately to complaints in accordance with their policy. They logged and investigated any complaints received and recorded any actions taken in response to resolve them. The service had received a number of compliments. One compliment said, "We couldn't have asked for anyone better when [name] had passed away. I hope one day you will look after me." Another compliment said, "[name of person] finds the [name of staff member] charming, diligent and enjoyable to be around."

From 31 July 2016, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. This means people's sensory and communication needs should be assessed and supported. We found the service was meeting this standard and had considered what additional support people may need to communicate effectively. This was recorded within their care plan.

The service supported people at the end of their life to have a comfortable, dignified and pain free death. This was reflected within people's care plans and people were supported to make choices about their death and the plans they wished to implement before dying. Staff had been trained in end of life care. We looked at the records of people who were coming to the end of their life. There was detailed information about

people's needs and wishes at this final stage.

Good

Is the service well-led?

Our findings

Overall, people told us the service was well managed. One person said, "I do think it's managed well. I have never had a problem in the two years I have been with them." Another person said, "I am happy. They just need to sort out the lateness of calls. That's all."

The service had a well-defined management structure, which gave clear lines of accountability. The registered manager retained overall responsibility for the service. Different leaders managed various sections of the business. This was supported by administration support which included a lead for training and development. They were able to demonstrate a good understanding and knowledge of the people who received a service from the agency as well as the staff team.

The provider's values were explained to staff through their induction programme and staff told us there was a positive culture where they felt included and consulted. All the staff we spoke with were positive about the service. One staff member said, "They are a good company and I would recommend them to my friends and family. They have stuck by me and helped me to develop myself. I would be happy for my relative to be cared for." Typical comments made about the registered manager, were that they were "approachable and understanding."

We looked at records related to the running of the service and found governance processes were in place. For example, the provider completed audits which helped to make sure that the quality of the service was maintained.

The service used a range of ways to seek the views of people who used the service. As well as talking to them on a regular basis, they sent surveys to relatives and professionals to seek their views and opinions. We saw the latest questionnaires that had been sent out. The feedback showed that people were satisfied with the care they received. Typical comments were, "You are the 'A' team." And, "The staff have first class skills." And, "We wold like to take this opportunity to congratulate and thank you for the superb and exemplary service."

Regular staff meetings took place which enabled staff to get together to discuss any issues or concerns. Care files and other confidential information about people was kept in the main office and stored securely. This ensured people's confidential information was only accessible to the necessary people.

Staff told us the service was well organised and they enjoyed working at the service because the registered manager had a visible presence. The employee survey had a high engagement rate. One comment made was, "I feel really listened too." And, "Thank you for the opportunities you have given me and helping me become more independent and furthering my career." And, "I am very happy here and I feel well supported."